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## Office of The Attorney General State of Connecticut

## TESTIMONY OF ATTORNEY GENERAL RICHARD BLUMENTHAL BEFORE THE PUBLIC HEALTH COMMITTEE MARCH 1, 2010

I appreciate the opportunity to support Senate Bill 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Centers.

This proposal requires that the annual Department of Public Health report on adverse events in hospitals and surgical centers include identifying the individual hospitals where such adverse events occurred. The proposal also requires the Department of Public Health to conduct random audits of these health care facilities to determine compliance with the reporting requirements and to examine more closely reported adverse events. The annual report would include the conclusion of such audit.

The proposal also protects any employee, applicant for employment or health care provider from retaliation because such person disclosed a hospital or outpatient surgical facility's failure to comply with the reporting and other requirements of the adverse events statute. Finally, the proposal establishes civil penalties for serious violations of public health laws by hospitals and surgical centers, including failure to report these adverse events.

The current law is a deadly and disgraceful failure, shielding hospitals and surgical centers from scrutiny and accountability and leaving patients in the dark. Medical mistakes causing death and serious illness may go unreported, undisclosed and uninvestigated, undermining patient protection. Gaping loopholes keeping most hospital medical errors secret -- including 116 that resulted in death -- are unconscionable and unacceptable.

Senate Bill 248 provides greater disclosure of — and accountability for — medical errors at hospitals, protecting patients and improving quality of care. Public disclosure provides a tremendous incentive to hospitals and surgical centers to take the necessary, often simple and common-sense, steps to prevent these 'never' events which should never happen and other potentially deadly mistakes.

Currently, 5 states have passed laws requiring hospital specific disclosure of adverse events -- Colorado, Indiana, Massachusetts, Minnesota and Washington.

Random audits of hospitals and surgical centers by the Department together with civil penalties and whistleblower protections will ensure that these institutions comply with reporting requirements and fully and fairly follow-through with promised improvements.

I urge the committee's favorable consideration of Senate Bill 248.